

State of Arizona  
Senate  
Forty-seventh Legislature  
Second Regular Session  
2006

# SENATE BILL 1085

AN ACT

AMENDING SECTION 36-2907, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2907.01; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM; PROVIDING FOR CONDITIONAL ENACTMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 36-2907, Arizona Revised Statutes, is amended to  
3 read:

4 36-2907. Covered health and medical services; modifications;  
5 related delivery of service requirements

6 A. Unless modified pursuant to this section, contractors shall provide  
7 the following medically necessary health and medical services:

8 1. Inpatient hospital services that are ordinarily furnished by a  
9 hospital for the care and treatment of inpatients and that are provided under  
10 the direction of a physician or a primary care practitioner. For the  
11 purposes of this section, inpatient hospital services excludes services in an  
12 institution for tuberculosis or mental diseases unless authorized under an  
13 approved section 1115 waiver.

14 2. Outpatient health services that are ordinarily provided in  
15 hospitals, clinics, offices and other health care facilities by licensed  
16 health care providers. Outpatient health services include services provided  
17 by or under the direction of a physician or a primary care practitioner but  
18 do not include occupational therapy, or speech therapy for eligible persons  
19 who are twenty-one years of age or older.

20 3. Other laboratory and x-ray services ordered by a physician or a  
21 primary care practitioner.

22 4. Medications that are ordered on prescription by a physician or a  
23 dentist licensed pursuant to title 32, chapter 11. Beginning January 1,  
24 2006, persons who are dually eligible for title XVIII and title XIX services  
25 must obtain available medications through a medicare licensed or certified  
26 medicare advantage prescription drug plan, a medicare prescription drug plan  
27 or any other entity authorized by medicare to provide a medicare part D  
28 prescription drug benefit.

29 5. Emergency dental care and extractions for persons who are at least  
30 twenty-one years of age.

31 6. Medical supplies, equipment and prosthetic devices, not including  
32 hearing aids, ordered by a physician or a primary care practitioner or  
33 dentures ordered by a dentist licensed pursuant to title 32, chapter 11.  
34 Suppliers of durable medical equipment shall provide the administration with  
35 complete information about the identity of each person who has an ownership  
36 or controlling interest in their business and shall comply with federal  
37 bonding requirements in a manner prescribed by the administration.

38 7. For persons who are at least twenty-one years of age, treatment of  
39 medical conditions of the eye excluding eye examinations for prescriptive  
40 lenses and the provision of prescriptive lenses.

41 8. Early and periodic health screening and diagnostic services as  
42 required by section 1905(r) of title XIX of the social security act for  
43 members who are under twenty-one years of age.

44 9. Family planning services that do not include abortion or abortion  
45 counseling. If a contractor elects not to provide family planning services,

1 this election does not disqualify the contractor from delivering all other  
2 covered health and medical services under this chapter. In that event, the  
3 administration may contract directly with another contractor, including an  
4 outpatient surgical center or a noncontracting provider, to deliver family  
5 planning services to a member who is enrolled with the contractor that elects  
6 not to provide family planning services.

7 10. Podiatry services performed by a podiatrist licensed pursuant to  
8 title 32, chapter 7 and ordered by a primary care physician or primary care  
9 practitioner.

10 11. Nonexperimental transplants approved for title XIX reimbursement.

11 12. Ambulance and nonambulance transportation.

12 13. BEGINNING OCTOBER 1, 2007, IF THE ADMINISTRATION RECEIVES A WAIVER  
13 PURSUANT TO SECTION 36-2907.01, MEDICALLY NECESSARY CHIROPRACTIC SERVICES FOR  
14 A MINIMUM OF TWELVE VISITS IN AN ANNUAL CONTRACT PERIOD FOR INDIVIDUALS  
15 SPECIFIED IN SECTION 36-2907.01. FOR THE PURPOSES OF THIS PARAGRAPH:

16 (a) "CHIROPRACTIC SERVICES" MEANS ONLY NONSURGICAL AND NONINVASIVE  
17 TREATMENT OF NECK AND BACK PAIN THROUGH PHYSIOTHERAPY, MUSCULOSKELETAL  
18 MANIPULATION AND OTHER PHYSICAL CORRECTIONS OF MUSCULOSKELETAL CONDITIONS  
19 WITHIN THE SCOPE OF THE CHIROPRACTIC PRACTICE.

20 (b) "MUSCULOSKELETAL" MEANS ANY FUNCTION OF THE MUSCULOSKELETAL SYSTEM  
21 THAT IS INTEGRATED WITH NEUROLOGICAL FUNCTION AND IS EXPRESSED BY BIOLOGICAL  
22 REGULATORY MECHANISMS.

23 B. Beginning on October 1, 2002, circumcision of newborn males is not  
24 a covered health and medical service.

25 C. The system shall pay noncontracting providers only for health and  
26 medical services as prescribed in subsection A of this section and as  
27 prescribed by rule.

28 D. The director shall adopt rules necessary to limit, to the extent  
29 possible, the scope, duration and amount of services, including maximum  
30 limitations for inpatient services that are consistent with federal  
31 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.  
32 344; 42 United States Code section 1396 (1980)). To the extent possible and  
33 practicable, these rules shall provide for the prior approval of medically  
34 necessary services provided pursuant to this chapter.

35 E. The director shall make available home health services in lieu of  
36 hospitalization pursuant to contracts awarded under this article. For the  
37 purposes of this subsection, "home health services" means the provision of  
38 nursing services, home health aide services or medical supplies, equipment  
39 and appliances, which are provided on a part-time or intermittent basis by a  
40 licensed home health agency within a member's residence based on the orders  
41 of a physician or a primary care practitioner. Home health agencies shall  
42 comply with the federal bonding requirements in a manner prescribed by the  
43 administration.

44 F. The director shall adopt rules for the coverage of behavioral  
45 health services for persons who are eligible under section 36-2901,

1 paragraph 6, subdivision (a). The administration shall contract with the  
2 department of health services for the delivery of all medically necessary  
3 behavioral health services to persons who are eligible under rules adopted  
4 pursuant to this subsection. The division of behavioral health in the  
5 department of health services shall establish a diagnostic and evaluation  
6 program to which other state agencies shall refer children who are not  
7 already enrolled pursuant to this chapter and who may be in need of  
8 behavioral health services. In addition to an evaluation, the division of  
9 behavioral health shall also identify children who may be eligible under  
10 section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5  
11 and shall refer the children to the appropriate agency responsible for making  
12 the final eligibility determination.

13 G. The director shall adopt rules for the provision of transportation  
14 services and rules providing for copayment by members for transportation for  
15 other than emergency purposes. Prior authorization is not required for  
16 medically necessary ambulance transportation services rendered to members or  
17 eligible persons initiated by dialing telephone number 911 or other  
18 designated emergency response systems.

19 H. The director may adopt rules to allow the administration, at the  
20 director's discretion, to use a second opinion procedure under which surgery  
21 may not be eligible for coverage pursuant to this chapter without  
22 documentation as to need by at least two physicians or primary care  
23 practitioners.

24 I. If the director does not receive bids within the amounts budgeted  
25 or if at any time the amount remaining in the Arizona health care cost  
26 containment system fund is insufficient to pay for full contract services for  
27 the remainder of the contract term, the administration, on notification to  
28 system contractors at least thirty days in advance, may modify the list of  
29 services required under subsection A of this section for persons defined as  
30 eligible other than those persons defined pursuant to section 36-2901,  
31 paragraph 6, subdivision (a). The director may also suspend services or may  
32 limit categories of expense for services defined as optional pursuant to  
33 title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United  
34 States Code section 1396 (1980)) for persons defined pursuant to section  
35 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not  
36 apply to the continuity of care for persons already receiving these services.

37 J. Additional, reduced or modified hospitalization and medical care  
38 benefits may be provided under the system to enrolled members who are  
39 eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d)  
40 or (e).

41 K. All health and medical services provided under this article shall  
42 be provided in the geographic service area of the member, except:

43 1. Emergency services and specialty services provided pursuant to  
44 section 36-2908.

1           2. That the director may permit the delivery of health and medical  
2 services in other than the geographic service area in this state or in an  
3 adjoining state if the director determines that medical practice patterns  
4 justify the delivery of services or a net reduction in transportation costs  
5 can reasonably be expected. Notwithstanding the definition of physician as  
6 prescribed in section 36-2901, if services are procured from a physician or  
7 primary care practitioner in an adjoining state, the physician or primary  
8 care practitioner shall be licensed to practice in that state pursuant to  
9 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or  
10 25 and shall complete a provider agreement for this state.

11           L. Covered outpatient services shall be subcontracted by a primary  
12 care physician or primary care practitioner to other licensed health care  
13 providers to the extent practicable for purposes including, but not limited  
14 to, making health care services available to underserved areas, reducing  
15 costs of providing medical care and reducing transportation costs.

16           M. The director shall adopt rules that prescribe the coordination of  
17 medical care for persons who are eligible for system services. The rules  
18 shall include provisions for the transfer of patients, the transfer of  
19 medical records and the initiation of medical care.

20           Sec. 2. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
21 amended by adding section 36-2907.01, to read:

22           36-2907.01. Chiropractic care pilot program; report

23           A. BEGINNING OCTOBER 1, 2007, THE CHIROPRACTIC CARE PILOT PROGRAM IS  
24 ESTABLISHED. THE ADMINISTRATION SHALL ENROLL THREE HUNDRED MEMBERS WHO HAVE  
25 PREVIOUSLY RECEIVED TREATMENT THROUGH THE SYSTEM FOR NECK OR BACK PAIN. THE  
26 ADMINISTRATION SHALL PRESCRIBE BY RULE ADDITIONAL REQUIREMENTS FOR PROGRAM  
27 PARTICIPANTS.

28           B. PROGRAM PARTICIPANTS ARE ELIGIBLE TO RECEIVE CHIROPRACTIC SERVICES  
29 PURSUANT TO SECTION 36-2907, SUBSECTION A, PARAGRAPH 13.

30           C. THE ADMINISTRATION SHALL CONDUCT AN EVALUATION OF THE PILOT PROGRAM  
31 AND SHALL SUBMIT A REPORT OF ITS FINDINGS TO THE GOVERNOR, THE SPEAKER OF THE  
32 HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE ON OR BEFORE  
33 SEPTEMBER 1, 2010. THE ADMINISTRATION SHALL PROVIDE A COPY OF THIS REPORT TO  
34 THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY,  
35 ARCHIVES AND PUBLIC RECORDS. THE EVALUATION SHALL INCLUDE THE FOLLOWING:

36           1. THE NUMBER OF PROGRAM PARTICIPANTS.

37           2. THE AVERAGE NUMBER OF TREATMENTS AND AVERAGE CLAIM COST OF CARE FOR  
38 EACH PROGRAM PARTICIPANT IN THE FISCAL YEAR BEFORE ENROLLING IN THE PILOT  
39 PROGRAM.

40           3. THE AVERAGE NUMBER OF TREATMENTS AND AVERAGE CLAIM COST OF CARE FOR  
41 EACH PROGRAM PARTICIPANT IN THE FISCAL YEAR AFTER ENROLLING IN THE PILOT  
42 PROGRAM.

43           4. AN ANALYSIS OF THE COST EFFECTIVENESS OF THE CHIROPRACTIC SERVICES  
44 BASED ON THE DATA PRESCRIBED IN PARAGRAPHS 2 AND 3 AND ANY OTHER RELEVANT  
45 DATA.

1           D. THE ADMINISTRATION SHALL APPLY TO THE CENTERS FOR MEDICARE AND  
2 MEDICAID SERVICES FOR A WAIVER OF THE REQUIREMENTS OF 42 UNITED STATES CODE  
3 SECTION 1396a(a)(10)(B).

4           Sec. 3. Conditional enactment

5           Section 36-2907.01, Arizona Revised Statutes, as added by this act,  
6 does not become effective unless the Arizona health care cost containment  
7 system administration receives a waiver of the requirements of 42 United  
8 States Code section 1396a(a)(10)(B) from the centers for medicare and  
9 medicaid services. The Arizona health care cost containment system  
10 administration shall notify in writing the director of the Arizona  
11 legislative council of the date on which the condition is met.

12           Sec. 4. Effective date

13           Section 36-2907, Arizona Revised Statutes, as amended by this act, is  
14 effective from and after September 30, 2007.